Behavioral Health Integration: A Closer Look at Three Models

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This is Phase Two of the Process

Phase One (the need for a new house)

- Work done in 2011 (Collette Croze) that demonstrated the need to better integrate care (mental health, substance abuse services, somatic care)

Phase Two (the blueprint for a new house) – THIS PHASE

- Recommend a ***model*** for behavioral health integration
  - Covered benefits
  - Covered populations
  - Framework for contracting (structure)
- The rules between the State and the MCO, BHO, and/or ASO

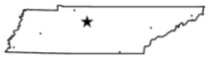
Phase Three (the design features to make the house a home)

- The downstream rules between the contractor and providers/beneficiaries
- Setting these rules via contracts, waivers, and regulations to execute the model. Examples: network requirements, referral requirements, authorization rules, provider rate assumptions,

Overview

Model 1: Protected Carve-In

Case Study: Tennessee



Model 2: Risk-Based Service Carve-Out

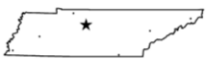
Case Study: Michigan

Case Study: Connecticut

Model 3: Population Carve-Out

Case Study: Maricopa County, Arizona

Carve-In: Tennessee Case Study



Scope of Services

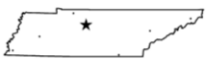
- MCOs responsible for all behavioral health. Behavioral health covered benefits include:
- Psychiatric inpatient
- 24-hour psychiatric residential treatment
- Outpatient mental health
- Inpatient, residential, and outpatient substance abuse services
- Mental health case management
- Psychiatric rehabilitative services
- Crisis services

Carve-In: Tennessee Model

Financial Model

- Full risk contract
- MCOs can subcontract behavioral health services, but the contract between the state and the MCO includes strict rules – including co-location of somatic and behavioral health staff and key personnel at the administrative level
- Capitation rates are risk-adjusted, and include behavioral health diagnoses
- Pay-for-performance quality incentive payments include bonuses related to behavioral health
- HEDIS measures
- The behavioral health dollars are not “protected”

Carve-In: Tennessee Model



Performance Measures

- MCOs are required to do two clinical performance improvement projects (one of which must be in behavioral health)
- Require NCQA accreditation
- Reports required on specialized support services, such as psychiatric hospital readmissions and post-discharge services
- The HEDIS measures that determine pay-for-performance include:
  - Antidepressant medication management
  - Follow-up care for children prescribed ADHD medication
  - Follow-up after hospitalization for mental illness
- 23 other performance standards include:
  - Length of time between psychiatric hospital discharge and first mental health service that qualifies as post-discharge (not to exceed 7 days)
  - Not more than 10% of members discharged from inpatient/residential behavioral health facility should be readmitted within 7 days; not more than 15% within 30 days

Protected Carve-In as It Could Be Applied in Maryland

Similar to Tennessee (examples)

- Risk adjustment based on factors that include behavioral health diagnoses
- Performance measures and P4P that include behavioral health
- Strict requirements on subcontracting behavioral health

Unique to Maryland (examples)

- Behavioral health dollars could be "protected"
- Additional requirements on subcontracting
  - Prohibition?
  - Single entity all MCOs must use?

Service Carve-Out with Performance Risk: Connecticut

Structure

- Statewide ASO for Medicaid-financed services
- Medicaid participating-providers and rates

Scope of Services

- Clinical authorization, utilization review/control, quality measurement, and data management
- Required to enhance coordination in the behavioral health system, assess network adequacy and improve overall service delivery
- Core clinical services include:
  - Intermediate inpatient psychiatric care
  - Acute psychiatric hospitalization
  - Medication evaluation/management
  - Substance abuse/detoxification services
  - Adult day treatment
  - Mental health group homes
  - Extended day treatment
- ASO must work collaboratively with local mental health authorities for additional grant covered services not under ASO's purview

Service Carve-Out with Performance Risk: Connecticut

Financial Model

- 7.5% of the ASO's management fee is dependent on meeting performance targets
- The state sets the performance standards and specific elements tied to the performance risk
- Failure to meet the measures requires a corrective action plan

Performance Measures

- Performance targets are tied to objectives such as:
  - Provider satisfaction
  - Member satisfaction
  - Access (penetration rates)
  - Other quality measures
  - Financial targets (e.g. produce cost-effectiveness)

Service Carve-Out with Performance Risk as It Could Be Applied in Maryland

Similar to Connecticut (examples)

- Portion of management fee tied to performance measures
- Some responsibilities for grant-funded coordination too

Unique to Maryland (examples)

- More explicit requirement to coordinate with MCOs (and tie to performance)
- Attach performance risk to outcomes outside behavioral health services alone (e.g., avoidable inpatient hospital admissions)

Service Carve-Out with insurance risk: Michigan

Scope of Services/Structure of Model

- Capitated managed care organizations (MCO) deliver somatic services, and first 20 outpatient mental health visits per person per year
- Capitated specialty behavioral health organization (BHO) delivers *specialty* mental health services for SMI population, all substance use services, and outpatient mental health visits beyond the 20 covered by the MCOs
- The MCO furnishes care coordination, to connect with the BHO
- BHO establishes its own network and rates, and is not bound to state Medicaid participating providers and rates, subject to certain state mandates/protections

Service Carve-Out with insurance risk: Michigan

Coordination by MCOs

- Each of the MCOs is responsible for coordinating with the BHO, e.g.:
  - MCO is responsible for coordinating care for enrollees who require integration of medical and behavioral health care
  - The MCO member handbook must contain information regarding the availability and process for accessing behavioral health services that are not the responsibility of the MCO
  - MCOs are contractually obligated to have agreements with behavioral health providers in the BHO's network. Agreements must address:
    - Emergency services
    - Pharmacy and laboratory service coordination
    - Medical coordination
    - Data and reporting
    - Quality assurance coordination
    - Grievance, appeal and dispute resolution

Service Carve-Out with Insurance Risk as It Could Be Applied in Maryland

Similar to Michigan (examples)

- BHO is responsible for (and at financial risk for) all specialty services for SMI population and substance use disorders, and for the services typically associated with low to moderate need beneficiaries once a certain utilization level is reached
- MCOs are required to coordinate with BHO, providers, and to furnish care coordination
- Contractual mechanisms resolve potential disputes

Unique to Maryland (examples)

- BHO similarly responsible for having arrangements and contracts with MCO providers, especially general acute care hospitals
- BHO similarly responsible for data and other elements to be furnished to MCO and its providers

Population Carve-Out: Maricopa, Arizona

Current System

- Arizona Medicaid contracts with MCOs through a capitated model for all acute care services except behavioral health
- Behavioral health services are carved out and Arizona Medicaid separately contracts with a statewide BHO-like entity for these services
- The BHO in turn contracts with Regional Behavioral Health Authorities (RBHAs) to provide behavioral health services in six defined geographic service areas

Reason Maricopa County is Moving to a Population Carve-Out

- Individuals with SMI were having to navigate anywhere from 2-4 systems to receive comprehensive care
- Financial incentives did not align to promote clinical integration and care coordination across domains (e.g., person with SMI who also has diabetes or congestive heart failure)

Population Carve-Out: Maricopa, Arizona

Population to be included in Carve-Out

- Medicaid-covered adults with SMI

Design

- Contract to be awarded to Specialty RBHA which will become a true and complete Health Home
- The entity must be a fully integrated health plan (no subcontracting), including fully-integrated care coordination and management, pharmacy management, care planning, quality management, risk assessment, systems platforms, predictive modeling, medical records, and payment
- Model will also require the entity to be a Medicare "Special Needs Plan" to coordinate and manage Medicare and Medicaid benefits for dual eligibles with SMI
- Must meet all CMS requirements for Health Homes (ACA Section 2703)
- Within Maricopa County, also provide all grant-funded services, subject to available funding
- Operate a crisis service delivery system

Population Carve-Out as It Could Be Applied in Maryland

Similar to Maricopa County, AZ (examples)

- Fully-integrated health plan, built off "BHO" chassis, at financial risk for both somatic and behavioral health
- Population defined for carve-out to be adults with SMI
- Compliant with CMS Health Home requirements
- Eligible to become Medicare Special Needs Plan, so that dual eligibles with SMI could be enrolled (in Arizona, dual eligibles already are in Medicaid managed LTC program, so only SMI adults would move into this model)

Unique to Maryland (examples)

- Not necessarily require dual eligibles with SMI to enroll (dual eligibles could remain in Medicaid fee-for-service for somatic care and, potentially, behavioral health too)
- Tie enrollment to substance use disorder condition too

Coming on Monday, July 23:

Document that distinguishes Phase Two (models)

from Phase Three (requirements/specifications in a model)

MARYLAND
Department of Health and Mental Hygiene
Office of Health Care Financing

To receive weekly e-mails regarding the behavioral health financing and integration process, or to submit comments, please contact:

bhintegration@dhmh.state.md.us